

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12192

CERTIFICATE OF DEATH

12203

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick c. LENGTH OF STAY IN IS 2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Lusby d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Virginia Barrett		4. DATE OF DEATH Month Day Year 9 20 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-89
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Allen		14. MOTHER'S MAIDEN NAME Sarah McCready	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-1252	
17. INFORMANT Address Daniel Barrett Lusby, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral DUE TO (c) Cerebral	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 17, 19 67 , to Sept. 20 19 67 , that (I) (we) last saw the deceased alive on Sept. 20 19 67 and that death occurred at 12203 , from causes and on the date stated above			
22a. SIGNATURE R deVillars		22b. DATE SIGNED 9-20-67	
22c. PHYSICIAN'S NAME (Type) R deVillars		22d. ADDRESS 52 Leonard St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 23 1967	
23c. NAME OF CEMETERY OR CREMATORY St Paul's Methodist Church - Lusby Calvert Md		23d. LOCATION (City or Town) (County) (State) Lusby Calvert Md	
24. FUNERAL DIRECTOR Ala. Horner & Son, Baltimore, Md		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12193

12204

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown c. LENGTH OF STAY IN 1b 04.1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown d. STREET ADDRESS 04.1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle B. Last Brooks		4. DATE OF DEATH Month 9 Day 30 Year 1967	
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-56-0788	
17. INFORMANT Mattie Kyler		Address Huntingtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension C.V. Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 65 to 9/30 , 19 67 , that (I) (we) last saw the deceased alive on 9/24 , 19 67 , and that death occurred at 1:30 A.M., from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/1/67	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS [Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-4-67	23c. NAME OF CEMETERY OR CREMATORY Bethel Way Of Cross	23d. LOCATION (City, town or county) (State) Huntingtown - Md.
24. FUNERAL DIRECTOR Pinkney E. Sewell		25a. REC'D BY REGISTRAR OCT 6 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
12194		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
		12205	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN lb 139 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Jane Last Buckler		4. DATE OF DEATH Month 9 Day 22 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 83 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Edward Bowen		14. MOTHER'S MAIDEN NAME Agnes V. Buckler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-6680	
17. INFORMANT Agnes Buckler Prince Frederick, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Memoria DUE TO (b) Hypertensive C.V. Buckler disease DUE TO (c) 4 years			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 6, 1967 , to Sept 22, 1967 , that (I) (we) last saw the deceased alive on Sept. 22, 1967 , and that death occurred at 3:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Page C. Jett		22b. DATE SIGNED 9-22-67	
22c. PHYSICIAN'S NAME (Type) PAGE C. JETT		22d. ADDRESS PRINCE FREDERICK	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Central Cemetery	23d. LOCATION (City or Town) (County) (State) Barstow Calvert, Md.
24. FUNERAL DIRECTOR A.A. Harkness		25a. REC'D BY REGISTRAR SEP 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Office of the

Director

United States Department of the Interior

Washington, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12193		CERTIFICATE OF DEATH	
12206			
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		c. LENGTH OF STAY IN Tb 15 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Barstow		d. STREET ADDRESS —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Luster Lee Carson		4. DATE OF DEATH September 16 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-85
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME B. W. Lowe		14. MOTHER'S MAIDEN NAME Georgia Ann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 242-22-7072	
17. INFORMANT Ruby Noland, Barstow, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Arterio Sclerosis x DUE TO (b) C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19__, to 9-15- , 19 67 , that (I) (we) last saw the deceased alive on 9-15-67 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Tasam El Damalouji, M.D.		22d. ADDRESS Prince Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY Southern Memorial Gardens, Prince Frederick, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR A.A. Harkness & Son, Port Republic, Md.		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

Delivery

Delivery

Primo, Francisco, M., 22 yrs.

Primo, Juan, 20 yrs.

Primo, Juan, 20 yrs.

Primo, Juan, 20 yrs.

Primo, Juan, 20 yrs.

Primo, Juan, 20 yrs.

Primo, Juan, 20 yrs.

Primo, Juan, 20 yrs.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12196

CERTIFICATE OF DEATH

12207

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN 1b 4 days 2 1/2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte Lottie Chase		4. DATE OF DEATH Month Day Year 9 14 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-12
9. AGE (In years lost birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Freeland		14. MOTHER'S MAIDEN NAME Mamie Chew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Cornelius Chase, Huntingtown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-10-67 , 19 67 , to 9-14 , 19 67 , that (I) (we) lost saw the deceased alive on 9-14 , 19 67 , and that death occurred 6:30PM , from causes and on the date stated above			
22a. SIGNATURE Osman Z. Ersoy		22b. DATE SIGNED 9-15-67	
22c. PHYSICIAN'S NAME (Type) Osman Z. Ersoy, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-17-67	23c. NAME OF CEMETERY OR CREMATORY Patuxent Church Cem.	23d. LOCATION (City or Town) (County) (State) Huntingtown, Md. Calvert
24. FUNERAL DIRECTOR Leroy E. Berry - Huntingtown, Md		25a. REC'D BY REGISTRAR SEP 19 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Continued from page 1

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10-1-77

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1219, CERTIFICATE OF DEATH 2208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY CALVERT
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND
c. LENGTH OF STAY IN 1b 04-1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RURAL PRINCE FREDERICK
CALVERT COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY CALVERT
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHESEPEAKE BEACH
d. STREET ADDRESS OLD BAYSIDE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
EDWARD ALBERT FAY

4. DATE OF DEATH Month Day Year
SEPT 17 1967

5. SEX MALE
6. COLOR OR RACE CAUCASIAN
7. MARRIED ☐ NEVER MARRIED ☐ **8. DATE OF BIRTH** Month Day Year
FEB 12, 1888
9. AGE (In years last birthday) 79 yrs. **IF UNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TYPE WRITER MECHANIC
10b. KIND OF BUSINESS OR INDUSTRY TYPE WRITERS, NEW YORK
11. BIRTHPLACE (County & State, or foreign country) U.S.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO
16. SOCIAL SECURITY NO. 577-03-1945
17. INFORMANT BARBARA FAY KELLY
Address 7113 BRIDAL PATH LAKE HYATTSVILLE, MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (c) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

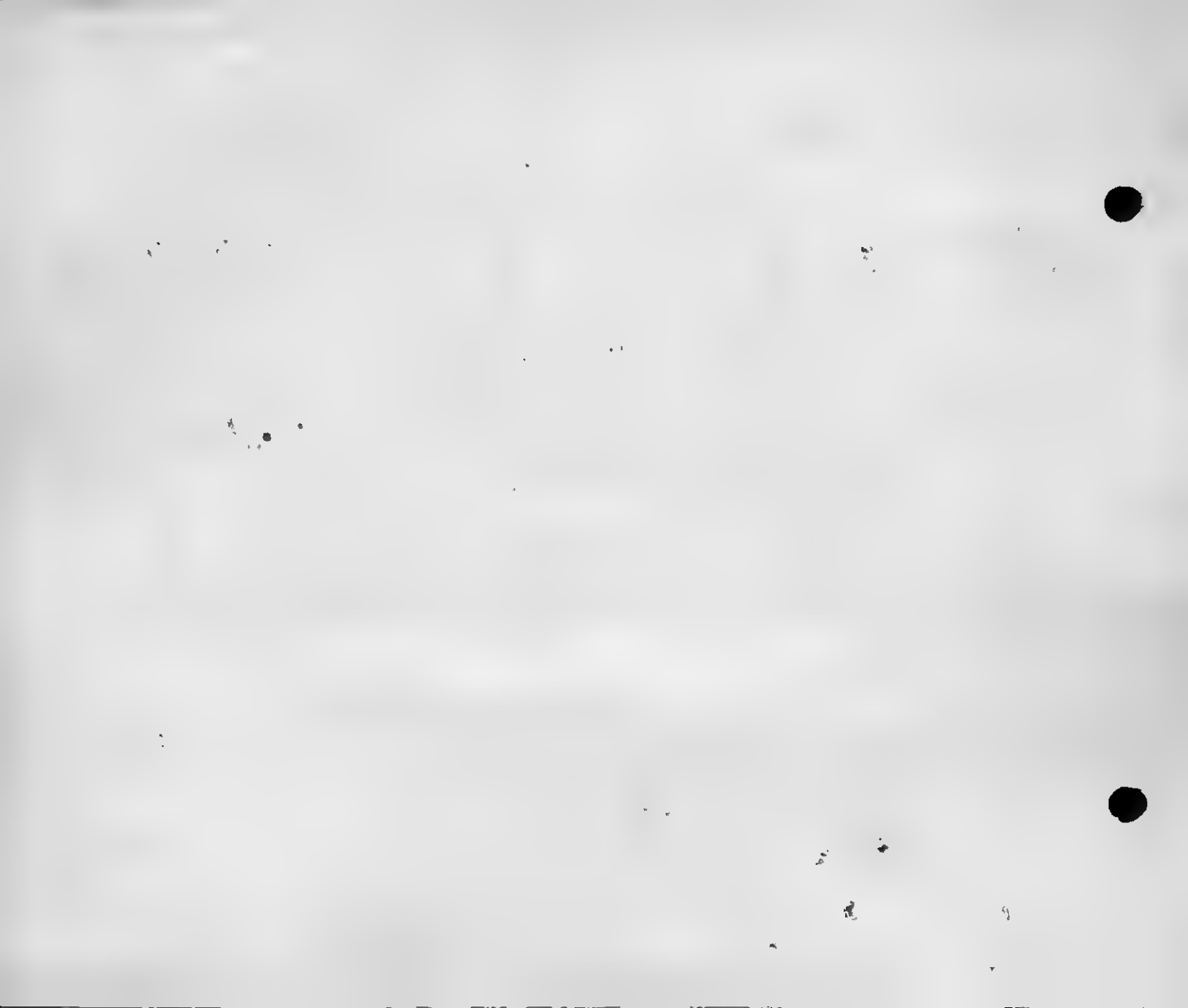
20a. ACCIDENT WAS UNDERLYING ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 9/17 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Huntingtown
20f. (City or town) (County) (State) 8/17

21. I certify that (I) (this hospital) attended the deceased from 9/17 1967 **to** 9/17 1967 **that (I) (we) last saw the deceased alive on** 9/17 1967 **and that death occurred at** 8:17 **M.** **from the causes and on the date stated above.**

22a. SIGNATURE George J. Weems **22b. DATE SIGNED** 9/17/67
22c. PHYSICIAN'S NAME (Type) GEORGE J. WEEMS **22d. ADDRESS** Huntingtown
22e. REC'D BY REGISTRAR Charles Judge **22f. REGISTRAR'S SIGNATURE** Charles Judge

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL **23b. DATE THEREOF** 20 SEPT, 1967 **23c. NAME OF CEMETERY OR CREMATORY** CEDAR HILL CEM **23d. LOCATION** (City, town or county) (State) SUITLAND MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co., RIVERDALE, MD. **25a. REC'D BY REGISTRAR** SEP 21 1967



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12198

CERTIFICATE OF DEATH

12209

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert Mary Beatrice MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Beatrice Hawkins				4. DATE OF DEATH September 16 19 67			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-91	
9. AGE (In years lost birthday) 76 yrs		10. IF UNDER 1 YEAR Months 1 Days 16 Hours 19 Min.		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Frank Randall	
13. FATHER'S NAME Frank Randall				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-48-9250		17. INFORMANT Address Sarah Hawkins, Dunkirk, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary atherosclerosis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/17/67 , 19 67 , to 9/16 , 19 67 , that (I) (we) last saw the deceased alive on 9/16 , 19 67 , and that death occurred at 5:00 M, from causes and on the date stated above							
22a. SIGNATURE R de Villard				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) R de Villard	
22c. PHYSICIAN'S NAME (Type) R de Villard				22d. ADDRESS 57 de Villard		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. (BURIAL) CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9/21/67		23c. NAME OF CEMETERY OR CREMATORY MOSES cem.		23d. LOCATION (City or Town) (County) (State) A.A. Co. Md.	
24. FUNERAL DIRECTOR Prince Frederick, Md.				25a. REC'D BY REGISTRAR SEP 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

12198

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN 1b 55 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS Rural-Chesapeake Beach	
3. NAME OF DECEASED (Type or print) First Middle Last Francis Matthew Hines		4. DATE OF DEATH Month Day Year 9 15 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1900
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) Retired Police		10b. KIND OF BUSINESS OR INDUSTRY Amusement Park	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Francis Hines		14. MOTHER'S MAIDEN NAME Elizabeth Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO 578 05 8525	
17. INFORMANT Mrs Margaret Hines		Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ischemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Thrombosis DUE TO (c) Cerebral Ischemia & Embolism		INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1965 , 19 65 to Sept 15, 1967 , that (I) (we) last saw the deceased alive on Sept 15, 1967 , and that death occurred at 2 1/2 M, from causes and on the date stated above.			
22a. SIGNATURE Page C. Jett, M.D.		22b. DATE SIGNED 9/16/67	
22c. PHYSICIAN'S NAME (Type) Page C. Jett, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt Harmony Cem.		23d. LOCATION (City or Town) (County) (State) Owings Calvert Md	
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12200		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		12211	
1 PLACE OF DEATH a COUNTY <u>Baltimore</u>		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a STATE <u>Md</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, give nearest RJRAL and give nearest county) <u>Breezy Mt</u>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, give nearest RJRAL and give nearest county) <u>Ches. Beach Breezy Mt</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <u>041</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>James Malcolm Jett</u>		4 DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/19/01</u>	9 AGE (In years last birthday) <u>66</u> yrs	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a USUAL OCCUPATION (Give kind of work and date, if most of work done, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11 BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Frank Jett</u>		14 MOTHER'S M A DEN NAME <u>Jenny Franklin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO		17 INFORMANT <u>Mrs Charlotte Jett, Same as 2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Age</u> DUE TO (c) <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN DEATH AND EXAMINATION <u>30 min</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had an attack and died in 30 min</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month <u>9</u> Day <u>18</u> Year <u>1967</u> Hour <u>3</u> pm		20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>	
20f (City or town) <u>Breezy Mt</u>		20g (County) <u>Calvert</u>		20h (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D.		22. DATE SIGNED <u>9/18/67</u>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Sept 21, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem</u>		23d LOCATION (City or town) (County) (State) <u>Clinton Pk large Md</u>	
24 FUNERAL DIRECTOR <u>Stutcheins Funeral Home Owings</u>		ADDRESS		25a REC'D BY REGISTRAR DATE <u>SEP 21 1967</u>	25b REGISTRAR'S SIGNATURE <u>James Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12201

CERTIFICATE OF DEATH

12212

1 PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick c. LENGTH OF STAY IN 1b 43 days		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mary Loretta Lea		4. DATE OF DEATH Month 9 Day 29 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-02 9. AGE (in years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) District of Columbia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Guy M. Roby		14. MOTHER'S MAIDEN NAME Catherine Conden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-8320	
17. INFORMANT James W. Lea, Jr.		Address Prince Frederick	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse - DUE TO Generalized carcinoma - (b) Cardioma of Breast. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1964 to Sept. 29, 1967 , that (I) (we) lost saw the deceased alive on 9/29/1967 , and that death occurred at 12:00 PM , from causes and on the date stated above			
22a. SIGNATURE Osman Z. Ersoy, M.D.		22b. DATE SIGNED 9-29-67	
22c. PHYSICIAN'S NAME (Type) Osman Z. Ersoy, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-3-1967	23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK	23d. LOCATION (City or Town) (County) (State) WASH. D.C.
24. FUNERAL DIRECTOR HANLON FUNERAL HOME - WASH. D.C.		25a. REC'D BY REGISTRAR Charles Judge DATE OCT 5 1967	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME
6M 1/64

12202

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12213

1 PLACE OF DEATH a COUNTY <u>CALVERT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a STATE <u>Md.</u> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FREDERICK</u>		c LENGTH OF STAY IN To <u>5 days</u>	c CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>BALTIMORE, Md.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CALVERT Co. Hospital</u>		d STREET ADDRESS <u>6007 HUNT RIDGE RD.</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>VIRGINIA C. MERRITT</u>	4 DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1967</u>		
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/5/1892</u>
9 AGE (In years lost birthday) <u>75</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>
11 BIRTHPLACE (State or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>CHARLES S. MERRITT</u>		14 MOTHER'S MAIDEN NAME <u>VIRGINIA CARR</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT <u>Hospital CHART</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PARALYSIS of ENTIRE body</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Injured Neck</u> DUE TO (c) <u>Automobile Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto Accident</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>AT INTERSECTION of ROAD under construction</u>	
20c TIME OF INJURY Month, Day, Year Hour <u>11:30</u> <u>pm</u> <u>9/1</u> 19 <u>67</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>	20f (City or town) (County) (State) <u>SUNDERLAND CALVERT Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HUGH W. WARD, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) <u>9-9/6/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>9-8-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK Cem.</u>	23d LOCATION (City or town) (County) (State) <u>BALTO. MD.</u>
24 FUNERAL DIRECTOR <u>John Burns Sons</u>		25a REC'D BY REGISTRAR DATE <u>SEP 11 1967</u>	
ADDRESS <u>Towson</u>		25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12214

1 PLACE OF DEATH a COUNTY <u>Calvert</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, 1 month prior to residence before admission) a STATE <u>MD</u> b COUNTY <u>Calvert</u>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. Hosp.</u>		e STREET ADDRESS <u>1000 E. 1st St.</u>	
3 NAME OF DECEASED (Type or print) <u>James William Muske</u>		4 DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 CO. OR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 25, 1952</u>
9 AGE (in years, last birthday) <u>15</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>	
11 Do U.S.A. OF EMPLOYMENT (Give kind of work done during most of working life, even if retired) <u>Student</u>		12 C ITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Samuel Hopper</u>		14 MOTHER'S MARDEN NAME <u>Elizabeth Hopper</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>none</u>	
17 INFORMANT <u>Samuel Hopper (step-father) Prince Frederick, Md.</u>		18 ADDRESS <u>1000 E. 1st St.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO <u>car accident</u> (b) <u>car left</u> DUE TO <u>car accident</u> (c) <u>car accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>Two on bicycle pulled across road in path of car</u>			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 18) <u>Car hit head side of bicycle</u>	
20c TIME OF INJURY Month Day Year <u>5:40 p.m. 9 30 1967</u>		20d INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Highway</u>		20f (City or town) <u>Prince Frederick, Calvert Co., Md.</u> (State) <u>Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H W Ward - Calvert Co.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>9/30/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct. 4, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Leesport Calvert Md.</u>
24 FUNERAL DIRECTOR <u>G. G. Harbess & Son, Port Republic, Md.</u>		25 REC'D BY REGISTRAR <u>OCT 3 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

12204

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12215

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Samuel Middle Washington Last Murray		4 DATE OF DEATH Month September Day 9 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8 DATE OF BIRTH 2-11-05 9 AGE (in years last birthday) 62 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Murray		14. MOTHER'S MAIDEN NAME Maggie Sanders	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-12-8845	
17 INFORMANT Medical records chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death DUE TO (b) Ch. of Esophagus DUE TO (c) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/5 , 19 67 , to 9/9 , 19 67 that (I) (we) last saw the deceased alive on 9/9 , 19 67 and that death occurred at 9 M, from causes and on the date stated above			
22a. SIGNATURE Roberto de Villarreal		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.		22d. ADDRESS St. Leonards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9 13-67	23c. NAME OF CEMETERY OR CREMATORY Brook Ch. Cem	23d. LOCATION (City or Town) (County) (State) Mutual Cal Md
24. FUNERAL DIRECTOR Linkney E. Seavel, Prince Frederick, Md		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE SEP 13 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12203 Item #9 Film #G393 9/25/67 ph											
12216											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick						c. LENGTH OF STAY IN 1b 4 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Chesapeake Beach					
d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Alverta Middle Brown Last Sewell						4. DATE OF DEATH Month 9 Day 13 Year 19 67					
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-26-03		9. AGE (In years last birthday) 63 1/2 yrs.		10. FUNERAL 1 YEAR 11. FUNERAL 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Brown						14. MOTHER'S MAIDEN NAME Rosie Brooks					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 213-38-4326		17. INFORMANT Marthalene Holland				Address Sunderland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1967 , to Sept. 13, 1967 , that (I) (we) last saw the deceased alive on Sept. 13, 1967 , and that death occurred at 2:15 AM , from the causes and on the date stated above.											
22a. SIGNATURE Osman Z. Ersoy						22b. DATE SIGNED 9-13-67					
22c. PHYSICIAN'S NAME (Type) Osman Z. Ersoy						22d. ADDRESS Prince Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-15-67		23c. NAME OF CEMETERY OR CREMATORY St. Edmonds Cem.		23d. LOCATION (City, town or county) (State) Calvert Co. Md.					
24. FUNERAL DIRECTOR Pinkney E. Sewell						25a. REC'D BY REGISTRAR SEP 20 1967					
25b. REGISTRAR'S SIGNATURE William Judge											

SI 3-38-4356

FOR STATE HEALTH DEPT.

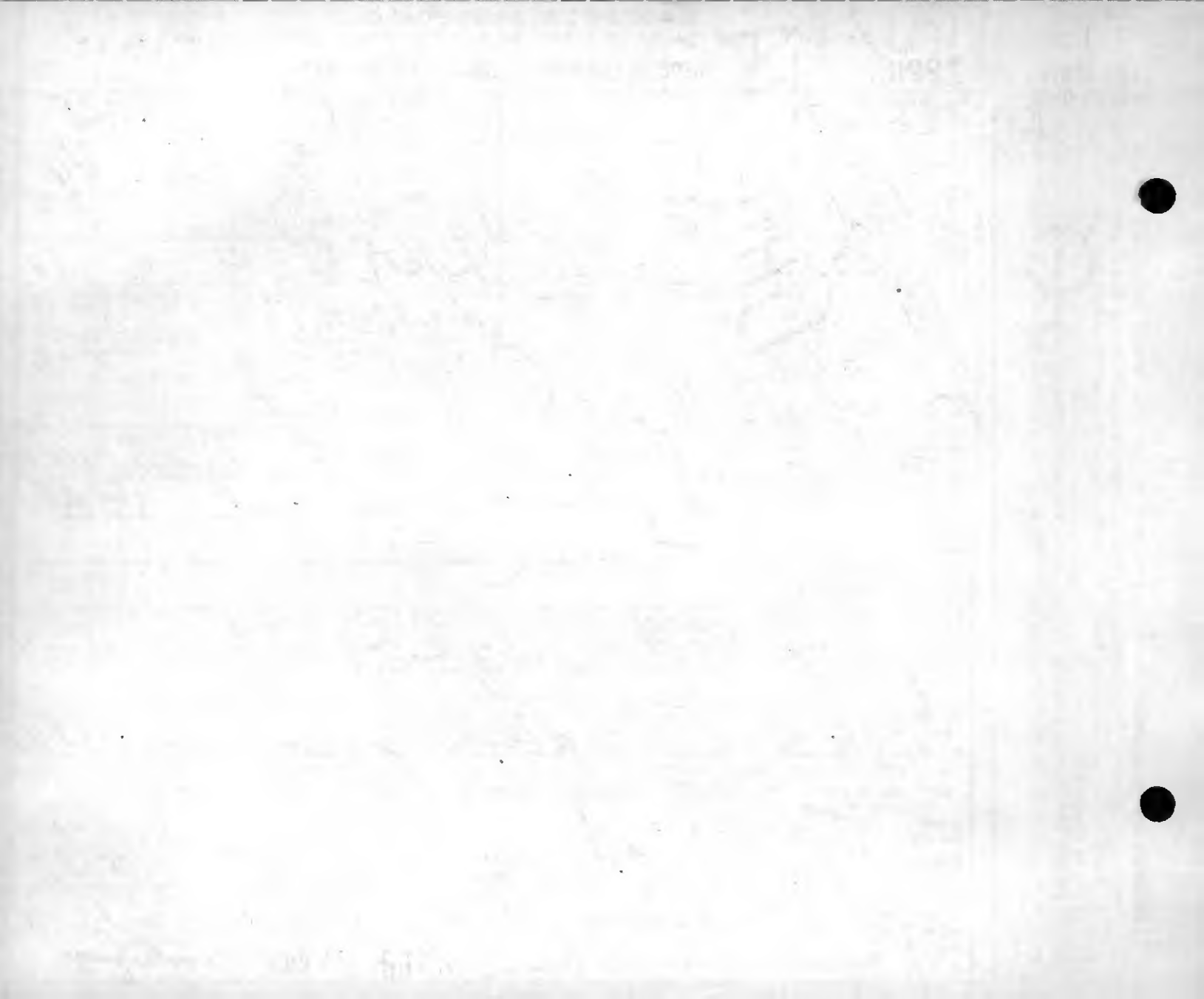
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H</u>		d. STREET ADDRESS <u>(rural)</u> 04.1	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Orville</u> Middle <u>Shifflett</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1953</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Orville Shifflett</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Myster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary Shifflett</u> Address <u>Prince Frederick, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull and</u> DUE TO <u>left leg (left)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Two days resting in hospital (one) but by car</u> 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 16.) <u>When leg pulled across leg</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:45 p.m. 9 30 1967</u>		20d. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <u>Deputy Prince Frederick Calvert MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>H.W. Ward</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.W. Ward, Calvert Co.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 4, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baistow, Calvert, Md.</u>	
24. FUNERAL DIRECTOR <u>A. G. Harkness Son, Port Republic, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick D.O.A.		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rodger Milbourne Woolford, Sr.		4. DATE OF DEATH Month 9 Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-'09
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Milbourne Woolford		14. MOTHER'S MAIDEN NAME Bertie Horseman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 217-16-7966	
17. INFORMANT Catherine P. Woolford		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C. V. D. (c)		INTERVAL BETWEEN DEATH AND EXAMINATION 90 min. Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) =			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) =	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 20, 1964 , to 9-13-67 , that (I) (we) last saw the deceased alive on 9-12-67 19 67 , and that death occurred at 5:45 A.M. from causes and on the date stated above			
22a. SIGNATURE Page C. Jett, M.D.		22b. DATE SIGNED 9-13-67	
22c. PHYSICIAN'S NAME (Type) Page C. Jett, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Solomons Methodist Cemetery	23d. LOCATION (City or Town) (County) (State) Solomons, Calvert, Md.
24. FUNERAL DIRECTOR W.A. Harkness & Son - Port Republic, Md.		25a. REC'D BY REGISTRAR SEP 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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